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MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craig L. Gray
Steven Jordan *SS*

SUBJECT: Implementation Update #86
Training for CST, IIH, DT, & MH/SA TCM
Training Opportunity: MINT for New Trainers
Endorsement Policy
CABHA First Responder Responsibility
Update to CABHA Letter of Attestation Process
CST/IIH Team Leader Clarification
Outpatient Codes, Limits, Referrals & PA
NCCI Update
Medicare & TPL Bypass for DA & PH
VO: Advantage of Online Request Submission
Due Process & PA Policy & Procedures

Training Requirements for Community Support Team, Intensive In-Home, Day Treatment and Mental Health/Substance Abuse Targeted Case Management

In the past several months, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Medical Assistance (DMA) have actively solicited stakeholder feedback regarding some of the training requirements. In an effort to address provider concerns, maintain clinical integrity, provide clarity, and allow flexibility, the Divisions are offering providers a choice of the following training options:

1. Person Centered Thinking

Effective immediately, Critical Access Behavioral Health Agencies (CABHAs) have the following options to meet the 12 Hour Person Centered Thinking training requirements set forth in Intensive In-Home (IIH), Community Support Team (CST), Day Treatment and Mental Health/Substance Abuse (MH/SA) Targeted Case Management (TCM) service definitions. The options are as follows:

- **Option A:**
Completion of the 12 hour Person-Centered Thinking training by a trainer certified through the Learning Community for Person Centered Practices that can be found at <http://www.unc.edu/depts/ddti/pct-training.html>. There is also a link to this website on the Person-Centered Information page of the DMH/DD/SAS website: <http://www.ncdhhs.gov/mhddsas/pcp.htm>.
- **Option B:**
Completion of the original 6 hour Person-Centered Thinking training requirement and the additional 6 hour MH/SA Person-Centered Thinking/Recovery training. Required elements may be found at: <http://www.ncdhhs.gov/mhddsas/cabha/recovpct.htm>. In addition, it is the Division's intention to develop a Person-Centered Thinking/Recovery curriculum and make it available as an alternative for use by providers.

These training options will apply to new and existing staff who are required to complete this 12 hour training requirement. The timeframe for completing the trainings are not affected by this policy change. Either of these 12 hour PC Thinking trainings will be portable when an employee changes jobs any time after completing the requirement as long as there is documentation of such training in the new employer's personnel records.

2. Motivational Interviewing Training

The requirements for the introductory Motivational Interviewing training have not changed; however, the 13 hour introductory Motivational Interviewing training requirement may be completed with a Motivational Interviewing Network Trainer (MINT) or through an online or web based training only if that training has been developed by a MINT trainer and is facilitated by a MINT trainer. This online or web based training will be portable when an employee changes jobs any time after completing the training as long as there is documentation of such training in the new employer's personnel records.

Training Opportunity: Motivational Interviewing Network Training for New Trainers

In October 2011, the Motivational Interviewing Network of Trainers (MINT) will provide a four-day MINT Training for New Trainers (TNT) sponsored by the DMH/DD/SAS that will be offered at no cost to approved applicants. The MINT TNT application process will begin on April 11, 2011. The MINT application approval process is determined by the MINT board. First priority will be given to applicants who are employed by a CABHA (especially those who provide IIH and CST services) and applicants employed by CABHAs and who have successfully completed the Wyoming Protocol Train-the-Trainer process. The first 40 applicants to meet criteria for the MINT TNT will be admitted to training. Applications will close on August 31, 2011 or whenever 40 candidates have been accepted for training, whichever comes first. A short waiting list may be retained in the event that an approved candidate withdraws prior to the beginning of training. CABHAs should expect to receive communication from the MINT board regarding the application requirements and process. This is an excellent opportunity for CABHAs to develop the capacity to offer MINT trainings and coaching within their organization and to other agencies and represents a commitment on the part of the DMH/DD/SAS to support the development of that capacity.

A subsequent two-day Motivational Interviewing Treatment Integrity coding system training will be offered for those who successfully complete the MINT TNT for use in coaching, training, supervision and quality assurance of the practice of Motivational Interviewing. Candidates who successfully complete the MINT TNT training will become members of the Motivational Interviewing Network of Trainers, and will be recognized as MI Trainers by the state of North Carolina. Applicants will be trained by MINT in order to train and coach other clinicians who deliver IIH or CST in their CABHA.

Endorsement Policy

The following revisions have been made to the DMH/DD/SAS Provider Endorsement Policy based on input and recommendations received at the CABHA regional trainings:

- CABHA certified agencies seeking endorsement for a new service (not yet endorsed to deliver) that is related to their **approved** service continuum (adult mental health, child mental health, adult substance abuse or child substance abuse) must follow the endorsement process as outlined in the DMH/DD/SAS Provider Endorsement Policy with the exception of the desk review and clinical interview. The

CABHA certified agency seeking endorsement for a new service that is related to their **approved** service continuum will only be required to complete the onsite review stage of service endorsement. The endorsing agency should conduct the onsite review within 20 calendar days of the receipt of the service endorsement application. The agency should hire all staff members to meet the staffing requirements of the service for which the provider is seeking to become newly endorsed by the date of the onsite review. The endorsing agency will complete a monitoring visit within 60 calendar days from the date of the DMA enrollment letter.

- CABHA certified agencies seeking endorsement for a new service (not yet endorsed to deliver) that is **not** related to their **approved** service continuum (e.g. approved service continuum is child mental health and provider is seeking endorsement for Psychosocial Rehabilitation) must follow the endorsement process as outlined in the DMH/DD/SAS Provider Endorsement Policy with the exception of the desk review. The CABHA certified agency seeking endorsement for a new service that **does not** relate to their **approved** service continuum will only be required to complete the clinical interview and onsite review stages of service endorsement. The endorsing agency should conduct the clinical interview within 20 calendar days of the receipt of the endorsement application. The agency should hire all staff members to meet the staffing requirements of the service for which the provider is seeking to become newly endorsed by the date of the clinical interview. The endorsing agency will complete a monitoring visit within 60 calendar days from the date of the DMA enrollment letter.
- A CABHA certified agency currently endorsed and enrolled to provide a service seeking to expand by delivering the **same** service at a new site and that site location has not been endorsed; or seeking to expand by adding the **same** service at a currently endorsed site must follow the endorsement process as outlined in DMH/DD/SAS Provider Endorsement Policy with the exception of the desk review, clinical interview and onsite review. Instead, the CABHA certified agency will submit a letter of attestation attesting compliance to the service definition along with supporting documentation to the local management entity (LME) in the catchment area where the new site will be located; or the LME in the catchment area where the currently endorsed site is located and the service (currently endorsed and enrolled to deliver) will be added. The LME will review the attestation letter and supporting documentation for completeness only. A desk review, clinical interview and onsite review will not be completed by the LME. The LME will update the standard agreement (MOA) or send the provider the MOA for signature as applicable within five calendar days of receipt of the letter of attestation and supporting documentation. The LME will send the Notification of Endorsement Action (NEA) letter granting endorsement to the CABHA certified agency within five calendar days of updating the MOA or receipt of the signed MOA as applicable. The LME that issued the NEA letter will complete a monitoring visit within 60 calendar days from the date of the DMA enrollment letter.

Additional Revisions to the DMH/DD/SAS Provider Endorsement Policy

- The Department of Health and Human Services (DHHS) good standing definition revised to reflect the DHHS good standing definition noted in 10A NCAC 22P.0402. The North Carolina Administrative Code (NCAC) can be accessed at the Office of Administrative Hearings website:
<http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2022%20-%20medical%20assistance%20eligibility/subchapter%20p/subchapter%20p%20rules.html>
- Definition for “Site” or “Site Location” has been expanded to include a statement that individuals (other than those receiving residential services) cannot receive services in the private residence of a provider agency employee(s). In addition, the definition has been expanded to include a statement that the “site” or “site location” must adhere to all state and federal privacy regulations and cannot be located at a business site that provides services not regulated by DHHS, its Divisions or a LME; or a licensed residential facility of six beds or less unless the agency is only providing residential services.
- Desk Review stage of service endorsement revised to allow the provider the opportunity to submit additional information.

- The process for providers seeking to pursue CABHA certification using the services of Community Support Team, Intensive In-Home or Day Treatment as part of their service continuum (as noted in Implementation Update #85 and the January Medicaid Bulletin) included in the policy.
- Revised policy requires at least one licensed clinician and one qualified professional (as defined in 10A NCAC 27G.0104) from the LME to conduct the clinical interview for services that require a licensed professional as part of the staffing requirement rather than two licensed clinicians from the LME. For services that do not require a licensed professional as part of the staffing requirement, the clinical interview may be conducted by two qualified professionals (as defined in 10A NCAC 27G.0104) from the LME. A MD or PhD from the endorsing agency should be present if the provider representative being interviewed is an MD or PhD.
- Service endorsement process for CAP-MR/DD (as noted in the 12/07 Provider Endorsement Policy) was included in the policy.
- A separate section for Business Entity Verification Renewal and Service Re-endorsement added.
- The wait time to reapply for a business verification or endorsement that has been involuntarily withdrawn changed from 6 months to 12 months to correspond with the DHHS good standing definition noted in 10A NCAC 22P.0402 (a)(2) and (b)(2).

Please refer to the revised DMH/DD/SAS Provider Endorsement Policy for additional details. The policy can be found at <http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm>. Revisions are effective April 15, 2011.

Critical Access Behavioral Health Agency First Responder Requirements

Consistent with 10A NCAC 22P .0302(e), CABHAs shall perform "first responder" crisis response 24 hours a day, 7 days a week, 365 days a year to all consumers accessing CABHA services, as follows: CABHAs shall serve as first responder when any consumer who has been assessed by the CABHA and is receiving services from the CABHA undergoes a crisis. For purposes of first responder requirements, crisis is defined as: a high level of mental or emotional distress, or an episode, which without immediate intervention will foreseeably result in the person's condition worsening, environmental instability or could result in harm to self or others.

All CABHAs shall be accessible 24/7/365 to respond directly to consumers and to collaborate with and provide guidance to other crisis responders regarding coordination of treatment for CABHA consumers in crisis. The first responder shall use the crisis plan developed with the consumer to coordinate and communicate with all other crisis responders (in accordance with HIPAA and 42 CFR Part 2) to ensure that the crisis plan is implemented.

All CABHAs shall have written policies and procedures in place that will be made available to all consumers, and shall include contact information for the consumer to first contact the CABHA rather than other crisis responders, such as hospital emergency departments and mobile crisis management teams. Each CABHA shall provide all consumers with a phone number to contact a live person 24/7/365 for use when crises occur. First response may be telephonic, but face to face intervention shall be attempted prior to referral or if necessary, in conjunction with other crisis responders. If a CABHA refers the consumer to an emergency facility or other crisis responder, the CABHA shall communicate with the crisis responder in order to facilitate coordination of care.

Update to Critical Access Behavioral Health Agency Letter of Attestation Process

As set forth in 10A NCAC 22P .0501, the necessary supporting documentation to meet CABHA requirements includes:

(10) A Certificate of Existence or Certificate of Authorization from the N. C. Secretary of State's Office in accordance with G. S. 55A-1-28 (for domestic and foreign corporations) or G.S. 57C-1-28 (for domestic and foreign limited liability companies).

This rule also addresses other required supporting documents noted in (1) - (9) of the rule. The content form of the CABHA Letter of Attestation is updated to reflect this change and can be found at: <http://www.ncdhhs.gov/mhddsas/cabha/index.htm>. This requirement takes effect immediately.

Community Support Team/Intensive In-Home Team Leader Clarification

Question: Can a qualified professional who is an applicant to be licensed serve as the team leader in a service that allows the team leader to be licensed or provisionally licensed (e.g., CST or IIH)?

Answer: In order to qualify to serve as a team leader in any enhanced service that allows a provisionally licensed individual to serve as the team leader, the professional must have already been granted the “provisional” status by their licensing board. The different licensing boards refer to this status of licensee by a variety of titles. The following list is the current title of the “provisionally” licensed professional according to the following licensing boards.

- North Carolina Psychology Board – Provisional Licensed Psychologist
- North Carolina Social Work Certification and Licensure Board – Provisional Licensed Clinical Social Worker
- North Carolina Substance Abuse Professional Practice Board – Provisional Licensed Clinical Addiction Specialist
- North Carolina Marriage and Family Therapy Licensure Board – Licensed Marriage and Family Therapist Associate
- North Carolina Board of Licensed Professional Counselors – Licensed Professional Counselor Associate

Clarification of Outpatient Behavioral Health CPT Codes, E/M Codes, Annual Limits, Referrals, and Prior Authorization

DMA has received several questions regarding outpatient behavioral health CPT codes, E/M codes, annual limits, referrals, and prior authorization. The intent of this article is to offer clarification.

Children

For children (under the age of 21 years), outpatient behavioral health services require a referral from a Community Care of N.C./Carolina ACCESS (CCNC/CA) primary care provider (PCP), a Medicaid-enrolled psychiatrist, or the LME prior to beginning outpatient behavioral health services. Prior authorization from the utilization review (UR) vendor (ValueOptions, Eastpointe LME or The Durham Center) is required for any visits beyond the initial 16 unmanaged visits. Please see the March 2011 Medicaid Bulletin (<http://www.ncdhhs.gov/dma/bulletin/0311bulletin.htm>) for guidance on counting unmanaged visits for children. The unmanaged visits are per the individual recipient per calendar year, January 1 through December 31. There is no annual visit limit for children. Enrolled licensed clinicians may bill the codes listed in DMA Clinical Coverage Policy 8C (<http://www.ncdhhs.gov/dma/mp/>). Provisionally licensed clinicians may provide services ‘incident to’ the physician or may provide services and bill through the LME. Please see the March 2009 Medicaid Bulletin (<http://www.ncdhhs.gov/dma/bulletin/0309bulletin.htm>) and DHHS Implementation Update #70 (<http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/>) for additional information.

Adults

For adults (ages 21 years and older), no referral is needed for outpatient behavioral health services if only the behavioral health codes listed in Clinical Coverage Policy 8C (<http://www.ncdhhs.gov/dma/mp/>) are billed (i.e., 90806, 90853). Prior authorization from the UR vendor (ValueOptions, Eastpointe LME or The Durham Center) is required for any visits beyond the initial eight unmanaged visits. Please see the March 2011 Medicaid Bulletin (<http://www.ncdhhs.gov/dma/bulletin/0311bulletin.htm>) for guidance on counting unmanaged visits for adults. The unmanaged visits are per the individual recipient per calendar year, January 1 through December 31. The behavioral health CPT codes listed in Clinical Coverage Policy 8C do not count towards the 22 annual visit (per State fiscal year July 1 through June 30) limit for adults. Information on the annual visit limit for adults is found at <http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm>.

Critical Access Behavioral Health Providers

All billable CABHA codes, including E/M codes, are listed in DHHS Implementation Update #73 (<http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/>). All of the E/M codes (i.e., 99213, 99201) billed by a psychiatrist, CABHA physician/psychiatrist, nurse practitioner or physician assistant billing 'incident to' the physician, count against the 22 annual visit limit for adults (per State fiscal year July 1 through June 30). Only CPT code 90862 does not count toward the annual visit limit. All of the codes that count towards the annual visit limit for adults can be found at <http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm>.

Because these E/M codes count towards the 22 annual visit limit, psychiatrists, CABHA physicians/psychiatrists, nurse practitioners, and physician assistants, must obtain a referral from the CCNC/CA PCP to bill for these codes. Some recipients with specific mental health diagnoses are exempt from the annual visit limit. The list of excluded diagnoses can be found at <http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm> and include schizophrenia and bipolar disorder. These E/M codes (99213, 99201, etc.), which are not specific to mental health, do not require prior authorization from the UR vendors (ValueOptions, Eastpointe LME, and The Durham Center) because they are not behavioral health-specific codes.

More information, including frequently asked questions (FAQs) about CCNC/CA, can be found at <http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm>. Additional information can be found in the managed care section of the *Basic Medicaid Billing Guide* at <http://www.ncdhhs.gov/dma/basicmed/>.

Providers must verify a recipient's participation with CCNC/CA and the recipient's PCP using one of the following methods:

1. Real Time Eligibility Verification (270/271 Transaction) – \$0.08 per transaction charge from HP Enterprise Services
2. Batch Eligibility Verification (270/271 Transaction) – no charge
3. Automated Voice Response (AVR) System – no charge
4. N.C. Electronic Claims Submission/Recipient Eligibility Verification Web Tool – no charge

For additional information on recipient eligibility verification, refer to DMA's web page at <http://www.ncdhhs.gov/dma/provider/RecipEligVerify.htm>.

National Correct Coding Initiative Update for Outpatient Behavioral Health Providers

As communicated in the October, December, January, February, and March Medicaid Bulletins and Implementation Update #85, the National Correct Coding Initiative (NCCI) became operational with date of service March 31, 2011. Attending (rendering) providers will not be able to bill certain pairs of codes for an individual recipient on the same date of service.

In general, assessment codes (for example, 90801, 90802, H0001, H0031) cannot be billed by the same attending provider on the same date of service as individual, group, and family therapy codes (for example, 90804 through 90808, 90847, 90849, H0004) or other assessment or psychological or developmental testing codes (for example, 96101, 96111).

Individual, group, and family therapy codes (90804, 90806, 90847, 90853, H0004, H0005) cannot be billed by the same attending provider for the same recipient for the same date of service as other individual, group, and family therapy codes (90804, 90806, 90847, 90853, H0004, H0005) or psychological or developmental testing codes (for example, 96101, 96111).

Psychological and developmental testing (for example, 96111, 96101) cannot be billed by the same attending provider for the same recipient for the same date of services as other psychological and developmental testing codes (for example, 96111, 96101).

In preparation for this implementation, testing of the NCCI edits was performed to determine the scope and volume of resulting denials. In a one-week period during the month of February, the most common behavioral health claim denials for CCI edits were identified as follows:

REJECTED CODE		PAID CODE	
90801	PSY DX INTERVIEW	90808	PSYTX OFFICE 75-80 MIN
90801	PSY DX INTERVIEW	90847	FAMILY PSYTX W/PATIENT
90801	PSY DX INTERVIEW	96111	DEVELOPMENTAL TEST EXTEND
90804	PSYTX OFFICE 20-30 MIN	90846	FAMILY PSYTX W/O PATIENT
90804	PSYTX OFFICE 20-30 MIN	90847	FAMILY PSYTX W/PATIENT
90806	PSYTX OFF 45-50 MIN	90846	FAMILY PSYTX W/O PATIENT
90806	PSYTX OFF 45-50 MIN	90847	FAMILY PSYTX W/PATIENT
90806	PSYTX OFF 45-50 MIN	90853	GROUP PSYCHOTHERAPY
90808	PSYTX OFFICE 75-80 MIN	90846	FAMILY PSYTX W/O PATIENT
90808	PSYTX OFFICE 75-80 MIN	90847	FAMILY PSYTX W/PATIENT
90808	PSYTX OFFICE 75-80 MIN	90853	GROUP PSYCHOTHERAPY
90812	INTAC PSYTX OFF 45-50 MIN	90846	FAMILY PSYTX W/O PATIENT
90812	INTAC PSYTX OFF 45-50 MIN	90847	FAMILY PSYTX W/PATIENT
90814	INTAC PSYTX OFF 75-80 MIN	90810	INTAC PSYTX OFF 20-30 MIN
90814	INTAC PSYTX OFF 75-80 MIN	90846	FAMILY PSYTX W/O PATIENT
90814	INTAC PSYTX OFF 75-80 MIN	90847	FAMILY PSYTX W/PATIENT
90814	INTAC PSYTX OFF 75-80 MIN	90857	INTAC GROUP PSYTX
90847	FAMILY PSYTX W/PATIENT	90846	FAMILY PSYTX W/O PATIENT
90862	MEDICATION MANAGEMENT	90806	PSYTX OFF 45-50 MIN

As indicated above, many practitioners will need to revise the schedule and delivery of authorized services to ensure that differing treatments are not provided on the same date of service.

For additional information, please see DMA's NCCI web page at <http://www.ncdhhs.gov/dma/provider/ncci.htm> or contact HP Enterprise Services at 1-800-688-6696 or 919-851-8888, option 3.

Medicare and Third Party Liability Bypass for Diagnostic Assessment and Partial Hospitalization

DMA has evaluated the data processing requirements for dually eligible (Medicare/Medicaid) recipients and for those recipients with private insurance who receive enhanced behavioral health services. The majority of all enhanced services bypass the requirement for first billing to Medicare and Third Party Liability (TPL) payors as these services and associated procedure codes are not covered under Medicare Part B and through private carriers.

It was intended that claims for HCPCS code T1023 (diagnostic assessment) and H0035 (partial hospitalization) be submitted to Medicare and private insurance as unbundled CPT codes. DMA has made the decision to retract this requirement. Therefore, denied claims for these two services may be resubmitted for payment if the reason for the denial is based on the recipient's dual eligibility for dates of service on March 20, 2004, and after. For claims that subsequently deny based on EOB 0018 or EOB 8918, the provider may follow the direction provided in Section 11 of the *Basic Medicaid Billing Guide* (<http://www.ncdhhs.gov/dma/basicmed/>) for time limit override. The Medicaid Resolution Inquiry Form is used to submit these claims for time limit overrides. No further retroactive reviews will be allowed, except based upon recipient eligibility.

ValueOptions: Advantages of Online Authorization Request Submission

Providers interested in submitting mental health and substance abuse service requests via ValueOptions ProviderConnect are encouraged to participate in regularly scheduled webinar training. To register for an upcoming session, visit http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm and scroll to the section titled *Provider Training Opportunities*. Click on the date you wish to attend and complete the registration form. The website is routinely updated with additional webinar dates.

Why transition from faxing authorization requests to electronic online submission via ValueOptions ProviderConnect?

- **Reliability**—online submission is the most reliable method to submit a request to ValueOptions. Receive immediate confirmation of receipt by ValueOptions.
- **Efficiency**—specified clinical information pre-populates on concurrent requests from the previous request.
- **Turn around time**—speed up turn around time by one to two days versus faxing.
- **Electronic notification of returns**—minimize lost days of authorization by submitting a corrected/complete request.

In addition, providers can save partial or complete drafts prior to submission and can print or download the request upon submission.

Attention All Providers: Due Process and Prior Authorization Policies and Procedures

DMA has received many questions from providers about the new Due Process and Prior Authorization Policies and Procedures, which go into effect on May 1, 2011. DMA will be issuing a Special Medicaid Bulletin on prior authorization in the next two weeks. This bulletin will contain critical information for providers of mh/dd/sa services. Medicaid administrative participation agreements require providers to be in compliance with all Implementation Updates **and** Medicaid Bulletins.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

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